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Supreme Court, U.S.
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Nos. 96-1377 & 96-1526

In The

Supreme Court of the United States

October Term, 1996

AETNA HEALTH PLANS OF CALIFORNIA, INC., *et al.*,

Petitioners,

-and-

INLAND HEALTHCARE GROUP/ARROWWEST PHYSICIAN ASSOCIATION,

Petitioner,

vs.

WILLIAM ARDARY, *et al.*,

Respondents.

On Petitions for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

REPLY BRIEF FOR PETITIONER ARROWWEST PHYSICIAN ASSOCIATION

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INTRODUCTION

Respondents continue to mischaracterize the nature of their claims in order to escape the exclusive Medicare jurisdictional scheme. Their opposition to *certiorari* also reveals a fundamental misunderstanding of the law governing Medicare's regulatory mechanism. As a result, Respondents misstate the significant consequences of the Ninth Circuit's erroneous decision in this case.

Medicare law must apply because the central premise of Respondents' case is that benefits due under a Medicare HMO plan were wrongfully denied. It is irrelevant that a Medicare program agent made the benefits determination, that the plan also offered some supplemental benefits, that the beneficiary is now deceased, and/or that a retrospective administrative determination could not fully compensate them for their loss. All of those contingencies are contemplated by the Medicare statutes and regulations, which indicate clearly that the Medicare administrative process applies in such cases. Similarly, the prior case law in this area establishes unequivocally that Respondents' insistence that they are suing to recover *damages* caused by the denial of benefits is a meaningless *non sequitur*, because this plainly is a *Medicare benefits* case.

Moreover, the negative reach of the Ninth Circuit's erroneous decision extends much further than Respondents suggest. Courts already are interpreting the decision as holding that any lawsuit for consequential damages resulting from an alleged wrongful denial of benefits by a Medicare HMO may be pursued in state court without prior exhaustion of the Medicare administrative process created for adjudicating the propriety of such denials.[1] Given the

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1. For example, in *Minka v. Pacificare of California, et al.*, Case No. SA CV 96-1200-GLT (EEx) (C.D. Cal., February 5, 1997) (order granting motion for remand), the district court relied on the Ninth Circuit's decision in this case in remanding the case to state court. The court ruled that "[t]he

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enormous number of people already enrolled and expected to enroll in Medicare HMOs, the Ninth Circuit's decision likely will generate a flood of litigation in the state and federal courts. Such litigation will undermine severely government efforts to reduce costs and achieve consistent implementation within the Medicare program.

Review by this Court is both appropriate and necessary because the Ninth Circuit's decision plainly creates a split in the circuits concerning the identification of claims "arising under" the Medicare Act, and because the potential negative consequences of this decision are so substantial.

FURTHER REASONS FOR GRANTING THE WRIT

Petitioner Arrowwest Physician Association ("Arrowwest") hereby adopts and incorporates by reference the Petitioners' Reply to Opposition to the Petition for a Writ of Certiorari filed by Aetna Health Plans of California, Inc., Aetna Life Insurance Company, AHP Holdings, Inc., Aetna Health Management, Inc. and Judith Hendrix (collectively "Aetna"). In addition, Arrowwest respectfully submits the following additional arguments in reply to Respondents' Brief in Opposition to the petitions for *certiorari*.

I.

RESPONDENTS HAD "STANDING" IN THE ADMINISTRATIVE PROCESS.

Respondents argue that they had no standing, and therefore no obligation, to pursue the Medicare administrative appeals

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state law claims, while predicated on Defendant's initial refusal to provide a [particular procedure], are not 'inextricably intertwined' with the denial of benefits. Plaintiff is not seeking payment for any benefit." Appendix D at 17a. *Minka* is not a wrongful death case, and it does not involve claims by the beneficiary's family.

process. Respondents' Brief in Opposition at 5, 21. Respondents are wrong. As set forth in Arrowwest's Petition for a Writ of Certiorari, the regulations implementing the Medicare HMO appeals process expressly provide that ***the parties to an HMO benefits decision, who have hearing rights and are bound by the administrative decision, include "[t]he legal representative of a deceased enrollee's estate."*** 42 C.F.R. § 417.610 (emphasis added). Respondents completely ignore this provision, which plainly demonstrates that the families of deceased enrollees are subject to the administrative appeals process and are bound by the resulting administrative determinations (subject to judicial review only after exhaustion of administrative remedies; *see* 42 U.S.C. §§ 405(g) and (h), 1395ff and mm). If that were not the case, the regulation would be meaningless. This analysis is not affected by the fact that Respondents are not seeking to recover the actual benefits because payment of the benefits would not adequately compensate their loss. *See Heckler v. Ringer*, 466 U.S. 602, 623 (1984) (plaintiffs' claim was barred even though they were challenging an agency ruling foreclosing recovery of benefits). Respondents also ignore the statutes and regulations providing that ***total denials of benefits*** (*i.e.*, determinations that the amount of benefits due is zero; *see* 42 U.S.C. § 1395ff(b)(1)(C)), including ***denials of emergency services*** (*see* 42 C.F.R. § 417.606(a)), are subject to the administrative appeals process, even though such denials obviously will result in death on some occasions, and thus the relief available will not fully compensate the loss. That is undoubtedly the reason why the regulations expressly apply to the representatives of deceased enrollees and make the administrative appeals process binding upon them.

II.

RESPONDENTS' CLAIMS "ARISE UNDER" THE MEDICARE ACT.

The crux of the Ardarys' claim is that benefits were wrongfully denied. That fact required them to challenge that denial through the Medicare administrative process. Respondents' assertion that "the benefits determination is not, *per se*, at issue" (Respondents' Brief in Opposition at 5) is plainly wrong. Even the most cursory reading of the Ardarys' complaint reveals that the *sine qua non* of their case is the decision by an Arrowwest representative not to authorize what the Ardarys contend was a covered benefit: an airlift transfer to another hospital.[2] As Petitioners (both Arrowwest and Aetna) have emphasized repeatedly, this case cannot be decided without determining whether Cynthia Ardary was entitled to the benefit of the airlift transfer under her Medicare HMO plan. Even the Ninth Circuit's opinion recognized that "their wrongful death complaint is 'predicated on' Arrowest's failure to authorize the airlift transfer. . . ." Appendix A at 9a. Thus, Respondents' claims are indeed "inextricably intertwined" with a benefits determination.

Moreover, as Aetna states in its Reply, an airlift transfer *is* covered by Medicare Part B where medically appropriate. The fact that the plan also may have offered some benefits beyond those covered by Medicare is irrelevant. Aetna's Reply at 7-8. If the transfer had been medically appropriate, then it would have been covered by Medicare; if not medically appropriate, it would not have been covered as a supplemental benefit either. Thus, their claims clearly "arise under" the Medicare Act. Indeed, whether a requested treatment or service was medically appropriate, and therefore subject to coverage, is precisely the kind of determination that is supposed to be made through the Medicare administrative

2. The Arrowwest representative who made the decision was Cynthia Ardary's own cardiologist, who, contrary to Respondents' claim, was *not* an "employee" of Arrowwest.

process, so that the program can maintain some control over what is covered and what is not. The courts certainly should not get involved until the agency at least has had an opportunity to resolve that question itself. This Court should grant review to prevent widespread judicial encroachment on what is supposed to be an agency function.

III.

THE MEDICARE AND ERISA PREEMPTION PROVISIONS MAY NOT BE IDENTICAL, BUT THEY ARE ANALOGOUS; THE LAW IN BOTH INSTANCES PROVIDES THAT SOME TYPES OF CLAIMS RELATING TO HEALTH BENEFITS MAY NOT BE PURSUED IN STATE COURT.

Respondents argue that because the Medicare Act does not contain the same broad preemption language found in ERISA, no aspect of ERISA law can be instructive in this case. Respondents' Opposition Brief at 14-18. That is incorrect. Both ERISA and the Medicare Act, by virtue of their express provisions and judicial interpretation, provide that certain types of claims regarding health benefits cannot be pursued in court. *See Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (ERISA preempted a malpractice claim against a medical consulting company for "precertification review" decisions); *Heckler v. Ringer*, 466 U.S. 602 (1984) (barring claims regarding an agency policy to deny Medicare payments for a particular treatment).

However, contrary to Respondents' contentions, Petitioners never have argued that the Medicare Act preempts all tort claims against providers. Clearly, it does not. Even ERISA, which Respondents' acknowledge has a far broader preemption provision, does not preempt all state law tort claims. Rather, ERISA law distinguishes between ***claims that benefits were wrongfully denied***, which are preempted, and ***claims that the quality of benefits***

actually provided fell below the standard of care (*i.e.*, medical malpractice claims), which are not. *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 355-361 (3rd Cir. 1995). Similarly, the Medicare Act makes clear that denials of Medicare benefits are subject to the exclusive Medicare appeals process. 42 U.S.C. §§ 405(g) and (h) and 1395ff(b). That does not mean that all tort claims against Medicare providers or Medicare HMOs are preempted, only that tort claims predicated on allegedly wrongful ***denials*** of benefits, such as those here, are foreclosed.

Respondents' suggestion that there is no reason to restrict tort suits for wrongful denials of benefits in the Medicare HMO context because "a Medicare HMO has no employee fund to administer" (Respondents' Brief in Opposition at 17) ignores the fact that Medicare HMOs are administering the ***taxpayers'*** funds. As this Court has ruled repeatedly, there is every reason to respect Congress's choice to restrict the remedies available under the Social Security Act generally, and the Medicare Act in particular, in order to ensure the perpetuation of the program as a whole. *See Schweiker v. Chilicky*, 487 U.S. 412, 429 (1988); *Heckler v. Ringer*, 466 U.S. 602, 627 (1984). The courts are not at liberty to provide litigants with remedies that Congress plainly has foreclosed, and Respondents cannot circumvent the will of Congress simply by pleading that the alleged wrongful denial of benefits was "negligent." If the remedies available to Medicare recipients or their survivors where benefits have been denied are inadequate, it is up to Congress to change that, not the courts.[3]

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3. Respondents' further assertion that the Medicare HMO system "has no need of a consistent and orderly administrative structure" (Respondents' Opposition Brief at 17) is absurd. In fact, the Department of Health and Human Services' commitment to a comprehensive administrative review process for Medicare HMOs is demonstrated by the newly released final rule establishing *expedited* appeal procedures for time-sensitive adverse benefits determinations by Medicare HMOs. 62 Fed. Reg. 23368 (April 30, 1997) (to be codified at

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IV.

RESPONDENTS' DISTINCTIONS OF AUTHORITIES CITED BY PETITIONERS ARE SPECIOUS.

Respondents are wrong to state that Aetna was merely a "provider" in this case (supposedly unlike the situation in *Bodimetric Health Services, Inc. v. Aetna Life & Casualty*, 903 F.2d 480 (7th Cir. 1990)), and therefore that 42 U.S.C. § 405(h) does not apply here. Respondents' Brief in Opposition at 13, 20. Aetna was ***not*** the healthcare provider in this case. As an HMO, Aetna contracted with Arrowwest, a group of physicians (among others), to provide care to its Senior Choice enrollees. Aetna was and is an "eligible organization" authorized to arrange for the provision of covered Medicare services to its Medicare-eligible enrollees. *See* 42 U.S.C. §§ 1395mm(b) (defining "eligible organization") and 1395mm(c)(2)(A) ("[t]he organization must provide to its members enrolled under this section, ***through providers and other persons that meet the applicable requirements of this subchapter*** . . . only those services covered . . . under this subchapter. . . . (emphasis added)). Thus, Respondents' argument that the administrative appeal provisions of 42 U.S.C. § 1395mm(c)(5)(B) do not apply to Aetna (Respondents' Brief in Opposition at 20) flies in the face of the plain wording of the law. The statute expressly states that "eligible organizations" such as Aetna ***are*** parties to administrative proceedings and any subsequent judicial review regarding benefits determinations. Respondents' argument that applying 42 U.S.C. § 405(h) (through § 1395mm(c)(5)(B)) to Medicare HMOs would insulate all Medicare providers from tort

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42 C.F.R. § 417). The background information provided in the Federal Register notes that all adverse benefits determinations by Medicare HMOs are subject to the Medicare administrative appeals process, a regulatory determination squarely at odds with the Ninth Circuit's decision here. 62 Fed. Reg. at 23369.

liability (Respondents' Brief in Opposition at 20) is plainly wrong, and the Ninth Circuit was wrong to accept it. (*See* Appendix A to Arrowwest's Petition for a Writ of Certiorari at 12a-13a.)[4]

Respondents' attempted distinction of *Hooker v. U.S. Department of Health & Human Services*, 858 F.2d 525 (9th Cir. 1988), also fails. According to Respondents, *Hooker* is inapplicable here because in that case the family of a deceased beneficiary was "suing the very parties 405(h) forbids actions against: The Secretary, the government and their employees." Respondents' Brief in Opposition at 25. This is another misunderstanding of Medicare law. Under 42 U.S.C. § 1395mm, Medicare HMOs are agents of the Secretary, and their determinations are expressly subject to the Medicare appeals process, including the limited judicial review provisions of § 405(h). 42 U.S.C. § 1395mm(c)(5)(B); *see also* 62 Fed. Reg. at 23369 (after exhaustion of procedures for reconsideration and Administrative Law Judge hearings, enrollees dissatisfied with adverse Medicare HMO benefits determinations "may pursue the same administrative and judicial review processes that are available to beneficiaries in fee-for-service. Thus, beneficiaries enrolled in HMOs . . . have appeal rights equivalent to those available in the fee-for-service program"). Therefore, *Hooker* manifestly is ***not*** distinguishable on the basis of the identity of the defendants. Similarly, the *Hooker* court's purported failure to distinguish *Jiminez-Nieves v. United States*, 682 F.2d 1 (1st Cir. 1982) is meaningless. That case (concerning the government's liability for the consequences of a key-punch error) ***did not involve any determination of what benefits were owed***, and thus it is entirely irrelevant to the Ninth Circuit's holding in *Hooker* and to this case.

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4. Respondents' and the Ninth Circuit's attempt to rely on legislative intent language from this Court's decision in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 680 (1986) (*see* Respondents Brief in Opposition at 15-16 and Appendix A at 12a), is misplaced in light of the clear direction from Congress that ***all denials*** are subject to the administrative review process, not merely "amount determinations." 42 U.S.C. § 1395ff(b).

Unquestionably, *Hooker* applies to this case. In *Hooker*, the plaintiffs were the surviving wife and children of a deceased social security disability benefits recipient. The plaintiffs brought state law tort claims against the government and various government employees individually, alleging that their termination of the decedent's disability benefits had led to his suicide. The Ninth Circuit held that the plaintiffs' claims were barred by Section 405(h), "***expressly reject[ing] the argument plaintiffs make here, that claims for damages caused by the Secretary's allegedly negligent acts do not 'arise under' the Act.***" 858 F.2d at 529 (emphasis added). According to the *Hooker* court, the plaintiffs' state law tort claims were "merely a disguised dispute with the Secretary." *Id.* at 530. The court explained:

> Plaintiffs contend that [defendant] negligently evaluated the medical evidence before it and wrongly concluded that Hooker was no longer disabled. This claim seeks an adjudication by a federal court that Hooker was indeed disabled within the meaning of the Act. Congress envisioned "just this type of claim," however, in creating an administrative remedial scheme by which an aggrieved person may contest the termination of benefits.

Id. at 529. In this case, just as in *Hooker*, plaintiffs allege that a negligent denial of benefits led to the death of their loved one. And in this case, just as in *Hooker*, allowing plaintiffs to proceed with this lawsuit would require a judge (in this instance a state court judge) to decide whether the disputed benefit of an airlift transfer was medically appropriate and subject to coverage under the circumstances. As the Ninth Circuit correctly recognized in *Hooker*, Congress has determined that this is not an appropriate or permissible determination for a judge to make.

CONCLUSION

All three branches of our government have made clear that Medicare HMO contractors are no different than the government itself with respect to their Medicare benefits determinations, which must be challenged through the administrative appeals process prescribed by § 405(h). That scheme is among the bargained-for inducements for otherwise private health insurers to assist the federal government in bringing managed care to the Medicare program. The Ninth Circuit's contrary holding undermines not only the text but also the intent of the law establishing the Medicare managed care program: to create and encourage public-private partnership to assure cost-effective, quality health care to millions of Medicare beneficiaries.

Review also is urgently needed to resolve the split in the circuits concerning what kinds of claims "arise under" the Medicare Act, because the proliferation of managed care will cause claims against Medicare HMOs to multiply rapidly.

For all the foregoing reasons, the petitions for writ of *certiorari* should be granted.

Respectfully submitted,

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APPENDIX D — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA FILED FEBRUARY 4, 1997

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

Case No. SA CV 96-1200-GLT (EEx)

Calendar Item #9

GEORGE MINKA,

Plaintiff,

vs.

PACIFICARE OF CALIFORNIA dba SECURE HORIZONS and PACIFICARE HEALTH SYSTEMS, PACIFICARE SYSTEMS INC., A DELAWARE CORPORATION, SHARP MISSION PARK MEDICAL GROUP, and DOES 1 to 100, inclusive

Defendants.

ORDER GRANTING MOTION TO REMAND

Plaintiff's Motion to Remand is GRANTED.

DISCUSSION

If at any time before the final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded. 28 U.S.C. § 1447(c).

Appendix D

Plaintiff moves to remand this case to state court for lack of subject matter jurisdiction because his causes of action do not "arise under" the Medicare Act ("Act") pursuant to *Ardary v. Aetna Health Plan of California, Inc.*, (9th Cir. 1996) 98 F.3d 496. The Court agrees with Plaintiff.

The Ninth Circuit in *Ardary* recently ruled the Medicare Act did not preclude state law claims against private Medicare providers where claims did not seek recovery of Medicare benefits, but rather sought compensatory and punitive damages resulting from tortious conduct of the providers. *See Ardary*, 98 F.3d 496. The dispositive question in determining whether federal jurisdiction exists is whether the claim "arises under" the Act. *Ardary*, 98 F.3d at 496; *see also Heckler v. Ringer*, (1984) 466 U.S. 602, 614-615, 104 S.Ct. 2013, 80 L.Ed.2d 622.

For a determination that a claim does not "arise under" the Act, the complaint must not "include any claims in which 'both the standing and the substantive basis for the presentation' of the claims is the Act.["] *Ardary*, 98 F.3d at 499 (citing *Heckler*, 466 U.S. at 615). Therefore, to deny this court jurisdiction, Plaintiff's standing to assert claims must rest on state common law, not the Act, and the state claims must not be "inextricably intertwined" with the denial of benefits. *Id.*

Plaintiff's complaint alleges sixteen causes of action against Defendants: breach of contract, bad faith breach of contract, fraud, specific performance, intentional and negligent interference with contractual relations, intentional and negligent infliction of emotional distress, intentional and negligent interference with physician/patient relationship, negligence, elder abuse, civil conspiracy, declaratory relief, and injunctive relief. Standing for these claims is premised on state common law theories and not the Act.

Moreover, the state law claims, while predicated on Defendant's initial refusal to provide a TMR, are not "inextricably intertwined" with the denial of benefits. Plaintiff is not seeking payment for any benefit. In fact, Plaintiff has already received the requested medical treatment. Plaintiff's claims are based on common law tort and contract principles, not the Act.

There is a strong presumption that Congress does not intend to preempt state law causes of action with a federal statute. *Ardary*, 98 F.3d at 501. There is nothing in the Act's legislative history to suggest it was designed to abolish all state remedies which might exist against a private Medicare provider for torts committed during its administration of Medicare benefits pursuant to a contract with HCFA. *Id.*

Because the state law claims brought by Plaintiff do not "arise under" the Act, the exclusive administrative procedures outlined for resolution of benefit determinations do not preempt Plaintiff's complaint.

DISPOSITION

Plaintiff's motion to remand is GRANTED.[1]

DATED: 2-4-97

s/ Gary L. Taylor
GARY L. TAYLOR
UNITED STATES DISTRICT JUDGE

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1. Since remand is granted, the court does not reach defendants' motion to dismiss, which can now be asserted in state court.